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ABSTRACT

"Attitude" is an oreintation crganized through experiences which respond consistently to an cbject, person, or situation. Attitude Therapy is aimed at modifying a patient's patterns of behavior which is viewed as a grcup of symptoms, rather than one specific symptom. Five attitude prescriptions employed in Attitude Therapy are: (1) kind firmness; (2) active friendliness; (3) passive friendliness; (4) no demand; (5) matter-of-fact. Tc date, the techniques and philosophy of this therapy have been used mainly in psychiatric settings, but they may be profitably used in community settings such as half-way houses, group homes, etc. Five strengths of this therapy are explored, including the fact that it is easily understood and involves all staff persons. Three disadvantages are: (1) difficulty in attaining consistency and adequate training among all staff members; (2) lack of applicability of scme attitude prescriptions to settings other than psychiatric; and (3) general lack of existing research. A list of references is included. (Author/PFS)

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A REVIEW OF ATTITUDE THERAPY;

The History, Concepts, Further Applications, Advantages and Disadvantages

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HISTORY

The term "attitude" has been used in psychology since psychology became recognized as a discipline. "Attitude" has many different meanings and different definitions. Since the concept of an attitude can be varied, it is necessary to establish a definition of the term "attitude". Dushkin (1970, p. 680) defines "attitude" as, "A predisposition to respond positively or negatively to particular objects or issues." Hilgard and Atkinson (1967, p. 619) define "attitude" as, "An orientation toward or away from some object, concept or situation (cf. attitude scale, opinion, prejudice)." Coleman (1964, p. 657) defines "attitude" as, "A consistent learned, emotionalized predisposition to respond in a particular way to a given object, person, or situation." A final definition of "attitude" is offered by Allport (1967, p. 8) as follows: "An attitude is a mental or neural state of readiness, organized through experience, exerting a directive or dynamic influence upon the individual's response to all objects and situations with which it is related." To the purpose of this paper, "attitude" shall be defined as "An orientation organized through experience, to respond consistently to an object, person, or situation."

Attitude Therapy, as reviewed in this paper, had its beginnings with the Menninger Foundation, Topeka, Kansas. The Guide To The Order Sheet (1950) was a structured manual for use in the treatment and overall management of psychiatric patients. The Order Sheet itself was a simple document which was used by the physician treating the patient, to convey his management prescriptions to nurses, attendants, and special therapists who were also working with the patient as part of the total treatment team. The management devices were ". . .statements of different approaches toward conflictual situations in the personality from which the most appropriate for the individual is chosen." These devices are formulated on the basis of the psychoanalytic principle that there are two strong primitive drives arising from the unconscious-- the aggressive (destructive) drives and the erotic (constructive) drives. It is assumed that an individual's maladjustment i.e. his illness (including the symptoms expressed through behavior, speech, and ideation) is the result of a disruption and redistribution of these drives. Fundamentally, it is assumed that the aggressive drive is the major cause of the difficulty, but always there are resulting disturbances in the erotic drive which are sometimes easier to attack than are the former, (p. 2).

The term "Attitude Therapy" was included in the Guide To The Order Sheet (1950) and characterized as being ". . . extremely important since, if we are to accomplish the therapeutic aim, it is essential that all persons who come in contact with the patient should maintain a uniform attitude insofar as possible; . . ." The assumption that a uniform attitude is necessary comes from the idea that verbal and non-verbal communication with each patient should be consistent, from all personnel working with the patient; and that "many patients" react to the feelings and manners projected by therapeutic personnel much more than they do to verbal communication. Thus, the history of Attitude Therapy was the concern that all individuals in contact with the psychiatric patient react in the same general manner; and further, these reactions formed the basis of the utilization of the management devices. It should be further noted that the Guide To The Order Sheet (1950) specified six general Attitudes: Active Friendliness (p. 9), Indulgence (p. 12), Passive Friendliness (p. 12), Watchfulness (p. 14), Matter-of-fact (p. 15), and Kind Firmness (p. 16), as well as additional special attitudes.

CONCEPTS OF ATTITUDE THERAPY

Attitude Therapy, as it is to be reviewed here, is an extension of the work of the Menninger Foundation.

Lamm and Folsom (1965, p. 308) explicitly state that, "This Attitude Therapy program is based on the treatment program at the Menninger Foundation." What then is Attitude Therapy? An introductory definition of Attitude Therapy is offered by Taulbee and Folsom (1973, p. 166) as follows; " . . . a procedure of process utilizing psychological principles to effect desired behavioral changes by structuring an environment in which a variety of consistently and systematically applied attitudes and techniques will reinforce adaptive behavior and extinguish maladaptive behavior." As Folsom stated in the Roche Report (1968), "We learn to modify our behavior by the influences other people have on us, by the ways they treat us, by the attitudes they have toward us."

In practice, Attitude Therapy is not concerned with the modification of a specific symptom of a patient; instead, the modification is aimed at a patient's pattern of behavior which consists of a group of symptoms. The basic premise is that most patients have multi-symptoms, and more of a patient's symptoms can be changed through identifying and modifying a pattern; because as the pattern is modified, individual symptoms will disappear (Folsom, 1966a, pp. 1 and 2). This premise is implemented in operation through prescribing an attitude which is to be employed by all people working with an individual patient, thus creating a therapeutic environment or treatment personality for the individual (Folsom, 1966c). Folsom and Taulbee

(1967, pp. 49 and 50) discuss the tangible existence of the treatment personality within the overall therapeutic environment. They state that, "It (the therapeutic personality) must involve the entire paid personnel of the hospital as well as the entire patient personnel of the hospital. These concepts can further include the family of the patient in all of their contacts with the patient, both through visits in person, contacts by telephone, contacts by mail, negative contacts by neglect, etc. Also involved will be volunteer workers to the hospital. The patient becomes a part of his own treatment process and through such involvement becomes a member of his own treatment team. Other patients are important members of the total treatment team also."

There are five attitude prescriptions which are employed in Attitude Therapy treatment. A description of each of these attitudes are as follows, and have been paraphrased from Folsom (1966b, pp. 25-34):

I. KIND FIRMNESS-The kind firmness attitude is used when working with a depressed individual. An individual who is prescribed an attitude of kind firmness is told what to do; no complaints are listened to, and no sympathy is given. Tasks assigned are monotonous and nongratifying. The individual is not criticized, but the way he is doing the job is criticized, and the individual is never to be allowed to do what he wants to do. The goal is to make the individual look at himself in a different light, and to

legitimately express his feelings instead of directing them inwardly.

II. ACTIVE FRIENDLINESS-The active friendliness attitude is used when working with a very withdrawn individual. An individual who is prescribed an attitude of active friendliness receives a large amount of friendship; the individual is not allowed to fail at anything that he attempts to do, and everyone working with the individual does everything possible to make the individual feel loved and cared for. Also, care is taken to guard the individual against any new experience of failure, however trivial it may seem. The goal is to help the individual to become a self-sufficient human being again through enabling the individual to regain courage and confidence to do things for himself.

III. PASSIVE FRIENDLINESS-The passive friendliness attitude is used when working with a defensive, suspicious individual. An individual who is prescribed an attitude of passive friendliness in not approached in an actively friendly manner; however, the people around the individual are available for friendship. The basic idea is to not move in too quickly, but instead, to offer friendship. The goal is to provide an environment in which the individual can reconstruct his defenses, and therefore cope with everyday occurences without overly defensive or suspicious reactions.

IV. NO DEMAND-The no demand attitude is prescribed for frightened, angry individuals who may be violent or striking-out, trying to destroy things around them. When this attitude

is used, it is an attempt to remove the pressures from an individual. The individual is told that the only things that he must do is to not leave the program without permission, to not harm himself or anyone else, and that he is to take his medication. No matter how hard the individual tries to make someone angry, no one will become angry at him. The goal of this attitude is to allow the individual to adjust to his environment with the idea that he does not have to strike out at people in order to survive.

V. MATTER-OF-FACT-The Matter-of-fact attitude is used when working with alcoholic, acting-out, organic, and manipulative individuals. An individual who is prescribed an attitude of matter-of-fact is treated in much the same way as most people deal with each other in day-to-day relationships. Very little emotion is shown; the individual is given a program to follow, and no excuses are accepted by the staff. The individual is told that he has messed up his life over the past years, and that it is time to deal with the future. The goal is to teach the individual that manipulation is unrewarding, and to teach the individual to face reality and its demands.

During the time that a patient is involved in Attitude Therapy, the specific attitude which is assigned may change. When such a change is indicated, the entire Treatment Team meets, and with the patient present, a discussion is held concerning the need for an attitude change. If it is decided by the Treatment Team that an attitude change is needed, the

new attitude is prescribed and the people in contact with the patient are informed of the new attitude prescription.

Although the present literature is not specific, Attitude Therapy works as a complement to other therapeutic processes. That is, an attitude is assigned, and changed, as the Treatment Team determines that the attitude program is necessary. When it is determined that the attitude program is no longer needed, the Treatment Team discontinues the attitude program, but may continue to use other therapeutic techniques until the patient is judged ready for discharge.

FURTHER APPLICATIONS

To date, the techniques and philosophy of Attitude Therapy have been used mainly in psychiatric settings. There would appear to be no definite reasons why the techniques would not be of benefit in community settings such as halfway houses, group homes and dormitories, work activity centers, sheltered workshops, and various educational settings. The attitudes prescribed and the objectives sought can be viewed as an attempt to control the direction of stimuli from the environment to the individual, and hence would also have an effect on the responses of the individual.

Perhaps it would be of benefit to consider a simplified example: Let us suppose that a team of professional* individuals were called together to remove a car which had gotten stuck in the mud. Now, since all the team members are professional, they all begin to work on the problem with only minimal communication between themselves, and practically no

communication with the driver of the car. There are, of course, many possible outcomes to this situation. The car may or may not be removed from the mud; the car may be removed from the mud, but may be pointing in the opposite direction in which the driver wishes to continue traveling; in the process, one or more of the professionals may be run over or injured in some other way; or possibly the car will be removed from the mud and will be pointed in the direction in which the driver wishes to travel. In such a system, the most desirable outcome (the last one cited) is left to chance occurance. Now let us suppose that when the team of professionals first begin to work on the problem that they all talk to each other and to the driver of the car, to determine where the driver of the car would like to go when the car is removed from the mud, and how best to accomplish the goal. In this second system, the most desirable outcome is very likely to occur.

Thus far, the example has shown the need for planning; however, the key to the planning is communication. When first reading the example, you assume that all the professionals are speaking in the same language, and that the driver of the car can understand each professional, as well as the professionals being able to understand each other. This is not necessarily true. Unless the professionals and driver are speaking the same language, using the same terms, and are dis-

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*Professional, meaning a person who specializes in a specific area i.e. tire construction and usage, motor construction, etc.

cussing the situation among themselves, the situation may remain the same or worsen. Without the essential element of planning through communication, a situation may be confronted haphazardly and/or inadequately. Far greater is the probability of full or partial success when communication among participants is involved in the planning.

Now let us consider our example in light of participants being served in a community or educational setting. The car and its driver becomes the client or participant, and the team of professionals is the staff and consultants of the agency. Attitude Therapy techniques is the communication which will ensure that all the professionals involved will be using the same language terms, and will be speaking in the same language - the Attitude Therapy language. This can result in rapid progress toward the desired goal, as well as in the attainment of that goal.

Perhaps one should also look at the concepts of Attitude Therapy in light of a controlled laboratory experiment. In the controlled laboratory experiment, as many stimuli as possible are removed from the experiment process so that subjects are reacting to a controlled set (or sometimes only one) of stimuli. Attitude Therapy in the community and educational settings would seem to have a similar effect of decreasing non-essential stimuli. Such a process should therefore help performance and may even increase the rate of performance.

One may relate this idea of learning performance through Attitude Therapy to reinforcement in learning. Travers (1972,

pp. 92 and 93) discusses the "expectancy hypothesis" in the interpretation of reinforcement. The essence of the hypothesis is that an individual produces a specific type of behavior because the individual expects to be rewarded or reinforced as a result of that behavior. Viewing Attitude Therapy in the light of expectancy, one finds the following sequence of events: an individual expects a response from his supervisor/teacher after he produces a type of behavior, the response is received, and reinforcement occurs.

In closing this section, Attitude Therapy techniques appear to be of most benefit when the most environmental time of the patient is spent within the treatment setting. Therefore, the more contact hours a participant is involved in within a program, the greater the potential effects of Attitude Therapy. From the available literature, Attitude Therapy is useful in a closed environment when used as a communication device, by the Treatment Team, in their overall treatment of the patient. It is however, questionable as to how effective Attitude Therapy would be in out-patient treatment or similar modalities.

ADVANTAGES

In considering the advantages of Attitude Therapy, the focus will not be to compare Attitude Therapy to other types of therapy; rather, the focus will be to point out general strengths of Attitude Therapy.

Attitude Therapy has many strengths; the greatest probable strength being the fact that the patient can also

be made a part of his own treatment team, which helps the team gain its ". . .common purpose - the restoring to normalcy of the individual-. . ." (Folsom, 1966c). Other strengths come from the fact that "Attitude Therapy is a carefully structured form of environmental therapy with simple concepts that are easy to demonstrate and easy to learn, even for new employees. . ." (Folsom, 1967, p. 1). Also, it must be remembered that Attitude Therapy is in essence, a communication device (Folsom, 1969) through which the therapist prescribes the type of communication required for each patient, with the other team members being responsible for the communication. Baker and Sawyer (1971, p. 18) have listed five advantages of Attitude Therapy (in relation to community rehabilitation programs):

"1. It is a technique that is easily understood by all levels of facility staff.

2. The technique involves all staff persons that come into contact with clients, and therefore helps all staff members have a part in the rehabilitation process.

3. The method impresses upon staff members the importance of their attitude toward clients as it effects client behavior.

4. The method is directed toward helping the client understand, take responsibility for, and change maladaptive behavioral response patterns.

5. The technique is easily integrated with other center programs as it does not involve special time, equipment, or space, and can be used with all clients regardless of disability."

DISADVANTAGES

As with the discussion of the advantages of Attitude Therapy, the discussion of the disadvantages will not focus on comparing Attitude Therapy with other techniques; rather, it will be the purpose to point out three types of disadvantages which are apparent from the literature currently available.

In the utilization of Attitude Therapy there is a need for consistency and training among all staff, and to some degree among patients. Although training can be easily presented to professionals and nonprofessionals, the training may conflict with existing interest, attitudes and values held by the trainees. Thus, it is necessary that existing interest, attitudes, and values correspond in some way to the philosophy of Attitude Therapy, or it is necessary to effect attitudinal change among the trainees. Attitude change, if it is necessary, is not a simple process. Another consideration in training is the fact that there is a need to train at as many levels as there are staff and patients. Thus, it may be necessary to initiate many different levels of training, but to have all these levels compliment each other so that all levels of staff and patients can gain a basic level of understanding to enable the communication which is vital to the overall system.

The second area of disadvantages is the fact that some of the attitude prescriptions may not be applicable to settings or patients other than psychiatric ones. A very basic question arises from the need to determine if all patients within a program need to be prescribed an attitude, or if only certain patients should be prescribed attitudes. If only certain patients

are prescribed an attitude and others are not, this could polarize the group which could also cause regression among some patients, simply because they did or did not receive an attitude prescription.

One certainly then must consider if the attitudes presented in the Concept section are applicable in every case. Take for example the Matter-of-fact attitude. The attitude could be prescribed for everyone if it could be stated to the effect that the program was just going to deal with the future. Not everyone has had the opportunity to mess up the past, and to make this statement may certainly cause a patient to begin a program with a poor self image because he believes he has messed up his past, when in reality he has had no control over the past.

The third area of disadvantages is the general lack of existing research. The author of this paper could not locate any research in relation to Attitude Therapy, and at this writing knows of only one such project which is currently being conducted. This is being conducted by the author himself in the Goodwill Industries Rehabilitation Center, Sioux City, Iowa. With more research, the feasibility and advisability of using Attitude Therapy in community and educational settings will become more apparent. However, Attitude Therapy has much to offer, and the techniques certainly have the potential to become a beneficial tool in community based and educational programs.

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